



Department  
for Education

## Statistical First Release

### Child Death Reviews – Year ending March 2015

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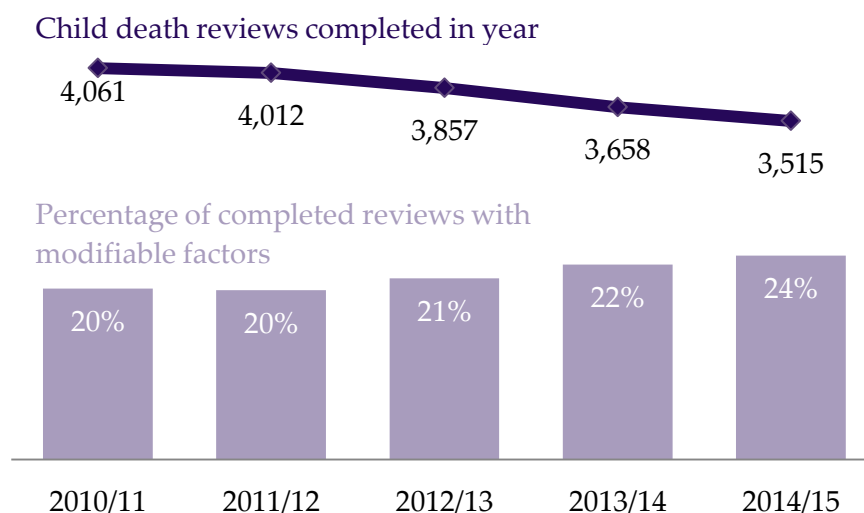
- 3,515** Reviews completed by Child Death Overview Panels in the year ending 31 March 2015 – a year on year decrease from 4,061 in 2011.
- 24%** The percentage of child death reviews (827 reviews) identified as having modifiable factors, an increase from 20% in 2011.
- 33%** The percentage of deaths reviewed which were due to a perinatal/neonatal event; this is broadly consistent with previous years.
- 64%** The percentage of deaths reviewed that were for children under one year old in the year ending 31 March 2015; this compares with 67% in 2011.

This Official Statistics Release contains information on child death reviews that were completed in the year running from 1 April 2014 to 31 March 2015. Data has been provided by all 148 Local Safeguarding Children Boards on behalf of 89 Child Death Overview Panels. From 1 April 2008, Local Safeguarding Children Boards have had a statutory duty to review deaths of all children from birth (excluding still born babies) up to 18 years old, who are normally resident within their area. This is known as the Child Death Review Process.

## 1. Trends for the period 2011-2015 (Table 1)

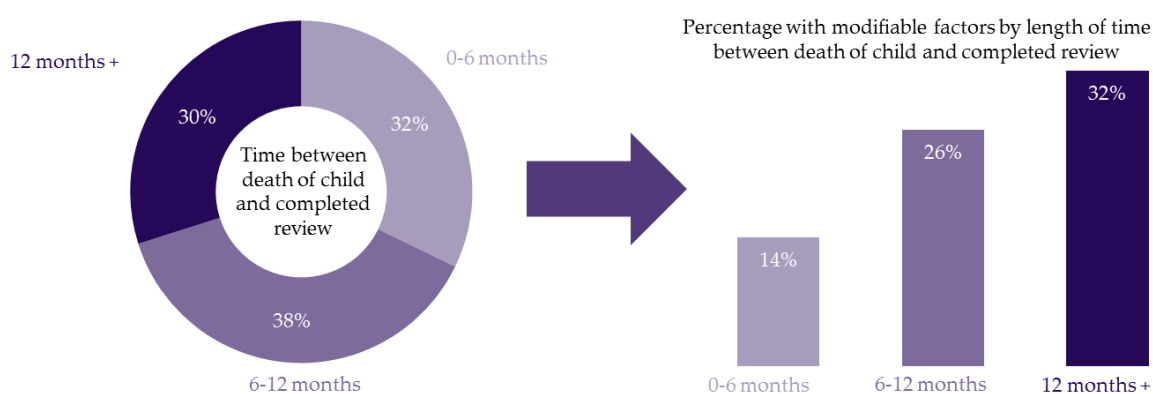
The number of child death reviews has decreased annually since the year ending 31 March 2011. Conversely, the number and percentage of reviews which were assessed as having modifiable factors has increased since 2011.

The decrease in the number of child death reviews is consistent with a decrease in the number of registered child deaths. Latest data from the Office for National Statistics (ONS) show that the number of child deaths decreased between the years ending 31 March 2012 and 31 March 2013 ([here](#)). Data for the year ending 31 March 2014 will be available from 15 July 2015.



## 2. Duration of reviews (Table 3)

70% of child deaths reviewed in the year were completed within 12 months of the child's death, a year-on-year decrease from 80% in the year ending 31 March 2011. However, reviews generally take longer if modifiable factors are identified in the death and there has been an increase in the percentage of deaths reviewed which have modifiable factors. In the year ending 31 March 2015, 14% of reviews which were completed in less than six months had identified modifiable factors, compared to 32% of reviews which took longer than a year to complete.

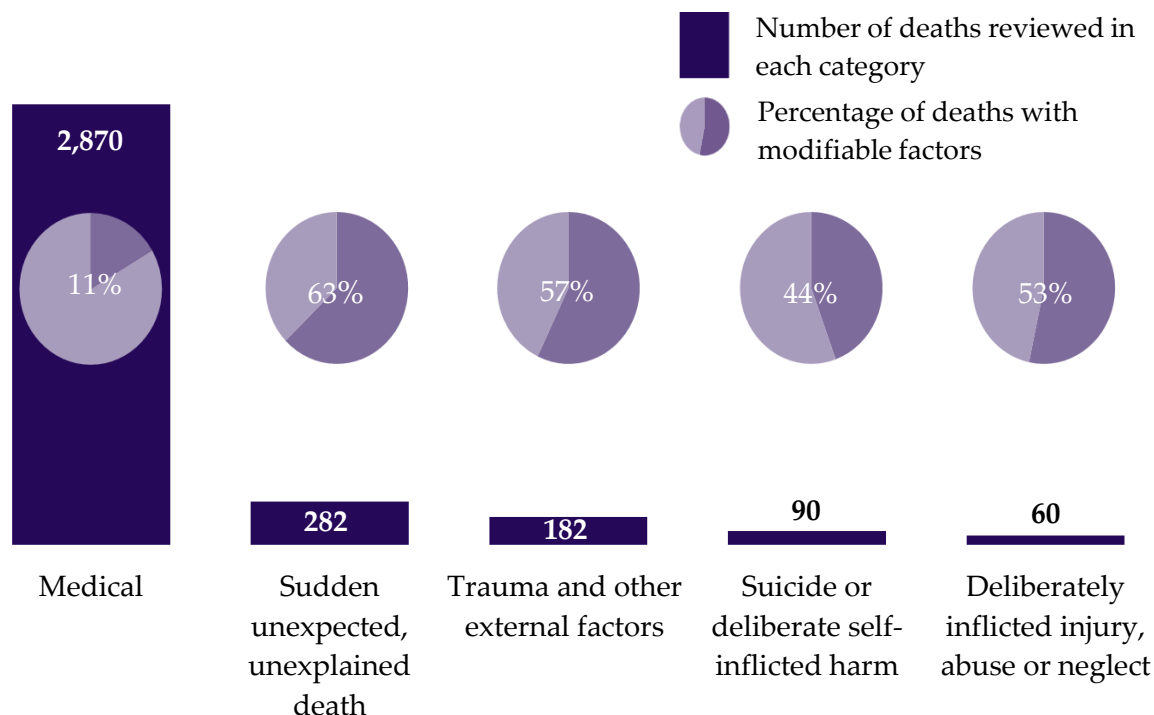


For child death reviews completed in year ending 31 March 2015

### 3. Category, event and location of death (Tables 4-6)

A third of all child death reviews were due to a perinatal/neonatal event; the percentage of these deaths with modifiable factors has steadily increased to 21% in 2015 from 10% in 2011. This compares to sudden, unexpected, unexplained deaths which represented less than 10% of all child death reviews, but where 63% of cases had modifiable factors. This is broadly consistent with previous years.

The following chart shows the numbers of reviews for category of death<sup>1</sup> together with the proportion of that category which had modifiable factors.



In the year ending 31 March 2015, 2,334 of the deaths reviewed occurred in an acute hospital and 149 in a hospice. This is consistent with over 2,870 of deaths reviewed that had a likely cause of the child's health problems and with 2,335 of reviews where the event which caused the death was a known life limiting condition or it was a neonatal death. However, deaths in an acute hospital had a lower percentage of modifiable factors (19%) than deaths in other locations.

By contrast, the number of deaths in public spaces is relatively small (129 deaths) but child death reviews identified modifiable factors in 43% of the cases. This is consistent with a high proportion of modifiable factors when the event that caused the death was either a road traffic accident/collision (50%) or drowning (67%).

<sup>1</sup> The "Medical" category includes perinatal/neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition; and chronic medical condition.

## **4. Serious case reviews, child protection plans and statutory orders** (Tables 7-9)

Due to small numbers, information in this section should be treated with caution.

A serious case review was carried out for 2% of all deaths reviewed in the year, which is consistent with previous years. Of the deaths reviewed in 2014-15 that were subject to a serious case review, 79% were deemed to have modifiable factors, compared to 22% of those not subject to a serious case review.

Around 2% of children (58 children out of 3,484) whose death was reviewed during the year were the subject of a child protection plan at the time of their death. Of these 58 children, 55% had modifiable factors identified compared to 23% for children who had never been the subject of a plan.

48 children out of 3,484 (1% of all reviews) were subject to a statutory order<sup>2</sup> at the time of their death, a decrease of one percentage point from the year ending 31 March 2014. 24% of children who had never been subject to statutory orders had modifiable factors identified, compared to 35% who were subject to statutory orders at the time of the death and 33% who had previously been subject to statutory orders.

## **5. Characteristics** (Table 10)

Consistent with previous years, approximately two out of three reviews completed were of children who died under the age of one; with 42% for children aged 0-27 days; and a further 22% for children aged between 28 and 364 days at the time of death. The age groups where child death reviews identified the highest proportion as having modifiable factors were children aged 28 to 364 days (34%) and those aged 15 to 17 years (28%).

Boys' deaths have consistently accounted for over half of deaths reviewed; but in a reversal of trend, the panels in 2015 were slightly more likely to identify modifiable factors in reviews of girls' deaths (26%) than in boys' deaths (23%).

Reviews of deaths of children from a White background have consistently accounted for around three out of five reviews completed. However, this is actually lower than the proportion of all children from a White background, which was 79%. By contrast, 16% of the deaths reviewed were for children from an Asian background, which is higher than the proportion of children from an Asian background in the population, at 10%. Note that population statistics are as at the 2011 census.

The Department collects information of reviews from deaths of asylum seeking children but this has not been included in the statistical first release due to small numbers in the groups.

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<sup>2</sup> Subject to any pre court disposals, Referral Orders, Youth Rehabilitation Orders, and Detention and Training Orders.

## 6. List of tables

The following tables are available in excel format on the department's statistics website: [Statistics: child death reviews](#).

### Reviews and timeliness

- 1 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards. Years ending 31 March 2011 to 2015
- 2 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by the year in which the child death occurred. Years ending 31 March 2011 to 2015
- 3 Time between the death of a child and the completion of the child death review. Years ending 31 March 2011 to 2015

### Cause and events

- 4 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by category of death. Year ending 31 March 2015
- 5 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by event which caused the child's death. Year ending 31 March 2015
- 6 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by location at time of the event or condition which led to the death. Year ending 31 March 2015

### Serious case reviews, child protection plans and statutory orders

- 7 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Serious Case Review status. Years ending 31 March 2011 to 2015
- 8 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Child Protection Plan status. Years ending 31 March 2011 to 2015
- 9 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Statutory Order status. Years ending 31 March 2011 to 2015

### Characteristics

- 10 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by age of the child at the time of death, gender and ethnicity. Year ending 31 March 2015

### Child Death Overview Panel meetings

- 11 Number of child deaths discussed by Child Death Overview Panels where the child was not normally resident within the Local Safeguarding Children Board area. Years ending 31 March 2011 to 2015
- 12 Number of times which the Child Death Overview Panel met. Years ending 31 March 2011 to 2015

## 7. Background information

- 1 The Local Safeguarding Children Boards data collection was introduced from 1 April 2008 and is designed to collect information on the number of child death reviews completed and the decisions made by Child Death Overview Panels on behalf of their Local Safeguarding Children Boards in England. Until 31 March 2010, panels were asked to assess whether a death was preventable or potentially preventable but due to difficulties distinguishing between these two categories, they were grouped and redefined as “modifiable factors”. Since 1 April 2010, Local Safeguarding Children Boards have therefore been required to determine whether there were modifiable factors in the death of a child when reviewing the death. Factors may be judged modifiable if they could use nationally or locally achievable interventions to reduce the risks of future child deaths. Reviewing deaths involves collating information on the cause, location and other circumstances of the death, but is not an investigation into why a child has died and it is not a serious case review, although a serious case review may be completed in respect of a death where abuse or neglect is considered to be a factor.
- 2 Reviews of similar deaths in subsequent years may have resulted in different assessments of whether there were modifiable factors. Decisions may have changed as the process evolved and as panels built a consistent approach to understanding ‘modifiable factors’. In addition, local trends may have begun to emerge which would suggest that deaths should be assessed as having had ‘modifiable factors’ when previously this would not have been the case.
- 3 A child death review is completed for every child that dies in England and includes:
  - a. collecting and analysing information about each death with a view to identifying –
    - i. any matters of concern affecting the safety and welfare of children in the area of the authority including any case giving rise to the need for a review
    - ii. any general public health or safety concerns arising from deaths of such children
  - b. putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Most child deaths do not lead to a serious case review. A serious case review is initiated where:

- a. abuse or neglect of a child is known or suspected; and
- b. either –
  - i. the child has died, or
  - ii. the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child’s welfare.

If it is thought, at any time, that the criteria for a serious case review might apply, the Chair of the Local Safeguarding Children Board should be contacted and the serious case review procedures followed. Not all deaths which result in a serious case review will be assessed as having modifiable factors.

- 4 For information on the child death review processes, please visit <https://www.gov.uk/childrens-services/safeguarding-children>. The data collection forms used to gather information for this publication and the related guidance can be found at <https://www.gov.uk/child-death-data-collection>.

## 8. Technical notes

- 1 The number of deaths registered as occurring during the year for children aged 0-17 years old is reported by the Office for National Statistics and latest data has been included in Table 1. Previously this table included estimates of the proportions of deaths that were reviewed, however these have been removed as the time lag between a death and a review means any proportions are difficult to interpret.
- 2 In a small number of cases (31 reviews in the year ending 31 March 2015) panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death. In other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. These cases have been included in the number of reviews completed in tables 1, 2 and 12 but excluded from subsequent analysis in tables 3 to 11.
- 3 In order to protect individual data, numbers from 1 to 5 inclusive have been suppressed and are shown as crosses (x). To ensure the suppressed number cannot be identified by simple arithmetic, secondary suppression may be required. This usually means that the next smallest number is also suppressed. Where any number is shown as zero (0), the original figure submitted was zero. Percentages are shown rounded to whole numbers but where the numerator was five or fewer or the denominator was 10 or fewer, they have been suppressed and replaced by a cross. Where a percentage is zero because the number from which that percentage has been calculated is a zero, the percentage is shown as zero. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
- 4 As part of a Government drive for data transparency in official publications supporting data for this publication have been made available. Within the supporting data the number of child death reviews completed and the number of these completed reviews which were identified as having modifiable factors has been provided at local authority level.
- 5 There are no planned revisions to this Statistical Release, however, if at a later date we need to make a revision this will comply with the Departmental revisions policy which is published at <https://www.gov.uk/government/organisations/department-for-education/about/statistics#announcements>.
- 6 This is an Official Statistics publication. Official Statistics are produced to high professional standards set out in the National Statistics Code of Practice. They undergo regular quality assurance reviews to ensure that they meet customer needs. They are produced free from any political interference.

## 9. Related publications

Earlier releases of Department for Education: Child death reviews are available [here](#).

The information page for the Child Death Review Programme for NHS Wales, including the 2014 Annual Report can be found [here](#).

Home Office data on homicides of children under 16 years old can be found [here](#) as part of a wider release: *Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14*.

The Statistical Bulletin *Deaths Registered in England and Wales, 2013* is produced by the Office for National Statistics and provides detailed data on infant mortality including perinatal and neonatal deaths. This release can be found [here](#). Note that the next edition of this release is scheduled for publication on 15 July 2015.

The Department for Education publish a two-year report *New Learning from Serious Case Reviews*. The latest release can be found [here](#).

The Ofsted release *Serious Incident Notifications* can be found [here](#) and provide the first information on notifications of serious incidents involving children that were notified to Ofsted by local authorities.

## 10. Got a query? Like to give feedback?

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# Department for Education

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